Exhibit C

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
CHERRY HOSPITAL
201 Stevens Mill Road • Goldsboro, N.C. 27530-1057 • Courier #01-11-05
Telephone Number (919) 731-3200 Fax (919)731-3785

Michael F. Easley, Governor
Dempsey Benton, Secretary
Michael S. Lancaster, M.D. and Leza Wainwright, Directors

Jack St. Clair, Ed.D., NHA
Cherry Hospital Director

NURSING DIRECTIVE
Effective Immediately

TO: RNs and LPNs in Nursing Service: **«FIRSTNAME» «LASTNAME»**
(«WK_TITLE»-«Unit»)

FROM: Bonnie Gray, MSN, RN, BC/Director of Nursing

DATE: August 19, 2008

SUBJ: **Patient Injuries, Medication Administration and Supervision of Patient Care**

When there is an incident or accident that results in a patient injury:

- The ward RN will assess the patient and notify the appropriate physician extender for follow-up. If there is no response from medical staff within 15 minutes, page through the Teleoperator again. If no response from the second page and a total of 30 minutes has elapsed, contact the Central Nursing Office Supervisor who will make contact with appropriate medical staff. For any emergency that requires an immediate response from the medical staff based on your assessment and nursing judgment, call a Code Blue through the Teleoperator.

- The ward RN will reassess the patient every shift and as needed until resolved.

- The ward RN must document the relevant facts of the incident/accident in the medical record. **Documentation on the incident/accident form does not replace medical record documentation.** At a minimum, the documentation should contain the following information:
  - date, time, and location of the incident/accident;
  - brief, but concise statement regarding circumstances surrounding the incident;
  - the condition of the patient, injuries sustained, treatment interventions rendered, and patient's response;
  - notification made (name, title/relationship, response); and
  - physician extender notification made.

- The ward RN must supervise patient care and insure completion of patient care activities as ordered. This includes but is not limited to vital signs, diagnostic studies, treatments such as dressing changes, intake and output, weights, meal consumption and medication administration. Medications must be administered by an RN or LPN as ordered. HCTs **CAN NOT** administer medications.

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NURSING DIRECTIVE
Effective Immediately

TO: Health Care Technicians (HCTs) in Nursing Services: «FIRSTNAME» «LASTNAME» («WK_TITLE»-«Unit»)

FROM: Bonnie Gray, MSN, RN, BC/Director of Nursing

DATE: August 19, 2008

SUBJ: **Patient Injuries, Medication Administration and Basic Nursing Care**

It is mandatory that HCTs report patient accidents, illnesses, injuries and/or refusals to the Registered Nurse (RN). **No exceptions** are allowed. Examples include but are not limited to falls, choking, altercations, new onset fever, broken skin, weight loss/gain of 5% or more during the last 30 days, meal refusals, or refusal to comply with fluid restriction or force fluid orders, etc. HCTs must also report to the RN whenever the patient "just doesn't look right" or something causes an uneasy feeling. The date, time and name of the RN notified must be documented in the progress notes.

HCTs **WILL NOT**, under any circumstances, administer medications to patients at Cherry Hospital. This exceeds their legal scope of practice in a hospital setting and violates our policy.

Nursing staff must accompany patients who leave the dining room to stand in the vending area or hallway prior to returning to the ward. Patients must be monitored in these areas.

Nursing Service Policy Manual

Section V W 1
Effective 8-20-08
Supersedes 5-19-08

Subject: Weights

Purpose: To ensure that patients are weighed upon admission and at least monthly to determine any significant weight loss/gain.

Authority:

Policy:

1. Weights will be obtained on admission and documented within 24 hours of admission to the hospital and at least every month thereafter, unless specified otherwise in the physician's orders.
2. Monthly weights are obtained and recorded on the Vital Signs/Weight/Glucose Flow Sheet by the Registered Nurse, Licensed Practical Nurse, or Health Care Technician.
3. Weights are recorded by entering the following in the appropriate column
    a. Date,
    b. Time,
    c. Weight or attempt to obtain weight, and
    d. Signature of person obtaining or attempting to obtain the weight.
4. Inability to obtain the weight is noted on the ward report.
5. Additional attempts to weigh the patient are documented until the weight has been obtained. Refusals are reported to the Ward RN.
6. Any weight loss/gain is assessed for significance using the last recorded weight as baseline. A loss/gain of 5% in the last 30 days is significant. The RN will assess possible contributing factors to the weight gain/loss and shall document findings in the progress notes. The RN will place the patient on sick call for review by a physician. The following considerations should always be included in the assessment of weight loss or gain:
    a. Is the patient on a special diet? Is the weight change resulting from the special diet? Is it a desirable change in weight in relation to diet and/or exercise?
    b. Has the patient recently been started on a diuretics or appetite booster?
    c. Assess for edema of feet, legs, and hands.
    d. Assess skin turgor.
    e. Assess for increased or decreased activity level.
    f. Assess overuse of snack machines or choices of snacks such as high sodium/high calorie foods.
    g. Assess whether visitors bring food.
    h. Does the patient steal food from others?
    i. Do others steal food from the patient?
    j. Does the patient have swallowing or chewing difficulties?
    k. Does the patient drop a lot of food on floor and need an adaptive device?
    l. re bowel movements regular?
7. An undesirable weight loss/gain is reported to the MD/Physician Extender via the Sick Call Log and notification is documented in the progress note.
8. Monitoring of patient weights is the responsibility of the RN. The RN will review the Flow Sheet to ensure that weights were obtained, and assess for changes. Follow up actions are documented in the progress note.

Attachment: None

Nursing Service Policy Manual

Section V W 1
Effective 8-20-08
Supersedes 5-19-08

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3. Weights are recorded by entering the following in the appropriate column
   a. Date,
   b. Time,
   c. Weight or attempt to obtain weight, and
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4. Inability to obtain the weight is noted on the ward report.
5. Additional attempts to weigh the patient are documented until the weight has been obtained. Refusals are reported to the Ward RN.
6. Any weight loss/gain is assessed for significance using the last recorded weight as baseline. A loss/gain of 5% in the last 30 days is significant. The RN will assess possible contributing factors to the weight gain/loss and shall document findings in the progress notes. The RN will place the patient on sick call for review by a physician. The following considerations should always be included in the assessment of weight loss or gain:
   a. Is the patient on a special diet? Is the weight change resulting from the special diet? Is it a desirable change in weight in relation to diet and/or exercise?
   b. Has the patient recently been started on a diuretics or appetite booster?
   c. Assess for edema of feet, legs, and hands.
   d. Assess skin turgor.
   e. Assess for increased or decreased activity level.
   f. Assess overuse of snack machines or choices of snacks such as high sodium/high calorie foods.
   g. Assess whether visitors bring food.
   h. Does the patient steal food from others?
   i. Do others steal food from the patient?
   j. Does the patient have swallowing or chewing difficulties?
   k. Does the patient drop a lot of food on floor and need an adaptive device?
   l. re bowel movements regular?
7. An undesirable weight loss/gain is reported to the MD/Physician Extender via the Sick Call Log and notification is documented in the progress note.

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8. _Monitoring of patient weights is the responsibility of the RN. The RN will review the Flow Sheet to ensure that weights were obtained, and assess for changes. Follow up actions are documented in the progress note.

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Attachment: None

Nursing Service Policy Manual

Section V W 1
Effective 5-19-08
Supersedes 1-15-01

Subject: Weights

Purpose: To ensure that patients are weighed upon admission and at least weekly to determine any significant weight loss/gain.

Authority:

Standard: Staff will monitor weights to ensure each patient maintains an acceptable nutritional status for his/her medical condition.

Policy:

1. Weights will be obtained on admission and documented within 24 hours of admission to the hospital and at least every week thereafter, unless specified otherwise in the physician's orders.

2. Weekly weights will be obtained and recorded on the Vital Signs/Weight/Glucose Flow Sheet by the Registered Nurse, Licensed Practical Nurse, or Health Care Technician.

3. Weights are recorded on the flow sheet by entering the following in the appropriate column

   - Date
   - Time
   - Weight or attempt to obtain weight
   - Signature of person obtaining or attempting to obtain the weight.

4. Inability to obtain the weight shall be noted on the ward report.

5. Further attempts to obtain weight shall be made daily and documented until the weight has been obtained. Refusals are reported to the Ward RN.

6. Any weight loss/gain shall be assessed for significance using these guidelines: Using the last recorded weight as baseline, assess for a loss/gain of 5% in last 30 days or a loss/gain of 10% in last 180 days. The RN will assess possible contributing factors to the weight gain/loss and shall document findings in the progress notes. The RN will place the patient on sick call for review by a physician. The following considerations should always be included in the assessment of weight loss or gain:

   - Diet - is the patient on a special diet? Is the weight change resulting from the diet? Is it a desirable change in weight?

- Medication - has the patient recently been started on diuretics or on an appetite booster?
- Assess for edema of feet, legs, and hands.
- Assess skin turgor.

- Assess for increased or decreased activity level
- Assess over use of snack machines or choices of snacks such as high sodium/high calorie foods
- Assess whether visitors bring food.
- Noncompliance with diet - Does patient steal food from others?
- Do others steal food from the patient?
- Does the patient have swallowing, chewing difficulties?
- Does the patient drop a lot of food on floor and need an adaptive device?
- Assess for regular bowel movements.

7. The patient who has been assessed and it has been determined that this is not a desirable change in weight shall be reweighed within one week. An undesirable weight loss/gain will be reported to the MD/Physician Extender within 24-hours. That notification shall be documented in the progress note as part of the RN's interventions.

8. Monitoring of weights is the responsibility of the RN. The RN will review the flow sheet to ensure that weights were obtained, and assess for changes. Follow up progress note is required for any action taken.

Attachment: None

Nursing Service Policy Manual

Section V I-3
Effective: 8/20/08
Supersedes: 5/19/08
Approved by Medical Staff: 8/12/08

Subject: Intake and Output

Purpose: To ensure proper monitoring of nutrition, hydration, urinary and bowel function.

Authority:

Standard: Accurate intake and output (I & O) is maintained for patients who need fluid and/or nutritional monitoring.

Policy:
An accurate record of the patient's fluid intake and output is documented on the Intake and Output Record. I & O may be indicated as a nursing intervention, or with a physician's order.

Procedures:

1. Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Health Care Technicians (HCTs) are responsible for collecting I & O data and recording on the I & O Worksheet. The I & O Worksheet is utilized during the shift to list all fluids the patient consumes orally, via feeding tube, and parenterally during an eight hour shift. All output in the form of urine, diarrhea, vomitus, gastric suction, and drainage from surgical tubes is measured during the shift.

2. The total amount of intake and output is calculated every shift and recorded in the designated area on the Intake and Output Record by the HCT. At the end of the 24 hour period, the grand total is recorded by the HCT at the end of the evening shift.

3. The RN is responsible for assessing intake and output daily and documenting at the end of the evening shift.

4. Staff implement **intake monitoring** and document cc's or ml's of fluid intake per shift:
   - if ordered by the medical provider,
   - if on fluid restriction,
   - if on force/push/encourage fluids, and/or
   - if patient has an enteral feeding tube.

5. Staff implement **general output monitoring** and document the number of voids each shift as reported by the patient or the number of wet diapers if incontinent of urine:
   - if ordered by the medical provider,
   - if on fluid restriction,
   - if on force/push/encourage fluids, and/or
   - if patient has enteral feeding tube.

6. Staff in the Psych Medical Unit (PMU) implement **strict I & O** monitoring for patients in the following situations and document all intake and output in cc's or ml's:
   - patients receiving intravenous (IV) fluids/piggybacks,
   - patients on IV diuretics,
   - patients with a medical order for strict I & O,
   - patients receiving enteral tube feeding, and/or
   - patients with an indwelling urinary catheter.

7. Patients on strict I & O should be in the Psych Medical (PMU) and are requested to utilize a urinal or other measuring device when voiding to measure urine output.

8. For **force/push/encourage fluids:**
   - Patient is offered 8 oz. (240 cc) of fluid q 2 hours from 6am to 9pm daily unless otherwise specified by the medical provider. This includes beverages consumed during meals and medication administration.
   - Proper fluids to offer include water, sugar-free tea, milk, up to 8 oz. of juice in a 24 hour period, small amounts of juice mixed with large amount of water and/or diet ginger ale or other sugar-free beverage.
   - Patient refusals to force/push/encourage fluids are reported to the medical provider.

9. For **fluid restriction:**
   - The restricted amount in cc's or ml's must be specified in the medical orders.
   - These patients will be on Constant Awareness (CA) 1:1 unless otherwise ordered by the medical provider.

Attachment: Intake and Output Worksheet

Patient Name:_____ Unit/Ward:_____ Date:_____

Intake and Output Worksheet

This form is not intended to be a part of the medical record. Utilize this form to calculate intake and output throughout the shift. Totals from this worksheet are to be documented on the Intake and Output Record at the end of every shift.

11-7 Shift

INTAKE

Time	Description	Amount in ml
Intake Total This Shift		

OUTPUT

Time	Description	Amount in ml
Output Total This Shift		

7-3 Shift

INTAKE

Time	Description	Amount in ml
Intake Total This Shift		

OUTPUT

Time	Description	Amount in ml
Output Total This Shift		

3-11 Shift

INTAKE

Time	Description	Amount in ml
Intake Total This Shift		

OUTPUT

Time	Description	Amount in ml
Output Total This Shift		

Measuring Equivalents

Juice Glass = 120 ml
Thickened liquid = 120 ml
Tea Tumbler = 360 ml
Teaspoon = 5 ml

Tea or Coffee Cup = 240 ml
Gelatin Cup = 120 ml
Soup Bowl = 180 ml
1 ounce = 30 ml

Sherbert/Ice Cream = 120 ml
Pudding = 105 ml
Milk = 240 ml

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Nursing Service Policy Manual

Section V I-3
Effective: 8/20/08
Supersedes: 5/19/08
Approved by Medical Staff: 8/12/08

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Subject: Intake and Output

Purpose: To ensure proper monitoring of nutrition, hydration, urinary and bowel function.

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Authority:

Standard: Accurate intake and output (I & O) is maintained for patients who need fluid and/or nutritional monitoring.

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Policy:
An accurate record of the patient's fluid intake and output is documented on the Intake and Output Record. I & O may be indicated as a nursing intervention, or with a physician's order.

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Procedures:

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1. Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Health Care Technicians (HCTs) are responsible for collecting I & O data and recording on the I & O Worksheet. The I & O Worksheet is utilized during the shift to list all fluids the patient consumes orally, via feeding tube, and parenterally during an eight hour shift. All output in the form of urine, diarrhea, vomitus, gastric suction, and drainage from surgical tubes is measured during the shift.

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2. The total amount of intake and output is calculated every shift and recorded in the designated area on the Intake and Output Record by the HCT. At the end of the 24 hour period, the grand total is recorded by the HCT at the end of the evening shift.

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3. The RN is responsible for assessing intake and output daily and documenting at the end of the evening shift.

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4. Staff implement **intake monitoring** and document cc's or ml's of fluid intake per shift:

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- if ordered by the medical provider,
- if on fluid restriction,
- if on force/push/encourage fluids, and/or
- if patient has an enteral feeding tube.

5. Staff implement **general output monitoring** and document the number of voids each shift as reported by the patient or the number of wet diapers if incontinent of urine:
   - if ordered by the medical provider,
   - if on fluid restriction,
   - if on force/push/encourage fluids, and/or
   - if patient has enteral feeding tube.

6. Staff in the Psych Medical Unit (PMU) implement **strict I & O** monitoring for patients in the following situations and document all intake and output in cc's or ml's:
   - patients receiving intravenous (IV) fluids/piggybacks,
   - patients on IV diuretics,
   - patients with a medical order for strict I & O,
   - patients receiving enteral tube feeding, and/or
   - patients with an indwelling urinary catheter.

7. Patients on strict I & O should be in the Psych Medical Unit (PMU) and are requested to utilize a urinal or other measuring device when voiding to measure urine output.

8. For **force/push/encourage fluids:**
   - Patient is offered 8 oz. (240 cc) of fluid q 2 hours from 6am to 9pm daily unless otherwise specified by the medical provider. This includes beverages consumed during meals and medication administration.
   - Proper fluids to offer include water, sugar-free tea, milk, up to 8 oz. of juice in a 24 hour period, small amounts of juice mixed with large amount of water and/or diet ginger ale or other sugar-free beverage.
   - Patient refusals to force/push/encourage fluids are reported to the medical provider.

9. For **fluid restriction:**
   - The restricted amount in cc's or ml's must be specified in the medical orders.
   - These patients will be on Constant Awareness (CA) 1:1 unless otherwise ordered by the medical provider.

Attachment: Intake and Output Worksheet

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<#>Patients receiving intravenous (IV) fluids/piggybacks¶
<#>Patients on IV diuretics¶
<#>Patients with a physician's order for fluid restriction or force fluids¶
<#>Patients receiving enteral tube feeding¶
<#>Patients with an indwelling urinary catheter¶
<#>Patients on I & O will be requested to utilize a urinal or other measuring device when voiding to measure urine output.¶
<#>The RN is responsible for assessing intake and output daily and documenting at the end of the evening shift. ¶

Patient Name:_____ Unit/Ward:_____ Date:_____

Intake and Output Worksheet

This form is not intended to be a part of the medical record. Utilize this form to calculate intake and output throughout the shift. Totals from this worksheet are to be documented on the Intake and Output Record at the end of every shift.

11-7 Shift

INTAKE			OUTPUT		
Time	Description	Amount in ml	Time	Description	Amount in ml
Intake Total This Shift			Output Total This Shift		

7-3 Shift

INTAKE			OUTPUT		
Time	Description	Amount in ml	Time	Description	Amount in ml
Intake Total This Shift			Output Total This Shift		

3-11 Shift

INTAKE			OUTPUT		
Time	Description	Amount in ml	Time	Description	Amount in ml
Intake Total This Shift			Output Total This Shift		

Measuring Equivalents

Juice Glass = 120 ml
Thickened liquid = 120 ml
Tea Tumbler = 360 ml
Teaspoon = 5 ml

Tea or Coffee Cup = 240 ml
Gelatin Cup = 120 ml
Soup Bowl = 180 ml
1 ounce = 30 ml

Sherbert/Ice Cream = 120 ml
Pudding = 105 ml
Milk = 240 ml .

Nursing Service Policy Manual

Section V I-3
Effective: 5-19-08
Supersedes: New Policy

Subject: Intake and Output

Purpose: To ensure proper nutrition, hydration, urinary and bowel function.

Authority:

Standard: Accurate Intake and Output (I & O) is maintained for patients who need fluid and/or nutritional monitoring.

Policy:

1. An accurate record of the patient's fluid intake and output is documented on the Intake and Output Record. I & O may be required as a nursing intervention, or with a physician's order.
2. Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Health Care Technicians (HCTs) are responsible for collecting I & O data and recording on the I & O Worksheet. The I & O Worksheet is utilized during the shift to list all fluids the patient consumes orally, via feeding tube, and parenterally during an eight hour shift. All output in the form of urine, diarrhea, vomitus, gastric suction, and drainage from surgical tubes is measured during the shift.
3. The total amount of intake and output is calculated every shift and recorded in the designated area on the Intake and Output Record. At the end of the 24 hour period, the grand total is recorded. Grand totals are recorded at the end of the evening shift.
4. Nursing will implement I & O monitoring for patients in the following situations:
    - Patients receiving intravenous (IV) fluids/piggybacks
    - Patients on IV diuretics
    - Patients with a physician's order for fluid restriction or force fluids
    - Patients receiving enteral tube feeding
    - Patients with an indwelling urinary catheter
5. Patients on I & O will be requested to utilize a urinal or other measuring device when voiding to measure urine output.
6. The RN is responsible for assessing intake and output daily and documenting at the end of the evening shift.

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11-7 Shift

INTAKE

Time	Description	Amount in ml
Intake Total This Shift		

OUTPUT

Time	Description	Amount in ml
Output Total This Shift		

7-3 Shift

INTAKE

Time	Description	Amount in ml
Intake Total This Shift		

OUTPUT

Time	Description	Amount in ml
Output Total This Shift		

3-11 Shift

INTAKE

Time	Description	Amount in ml
Intake Total This Shift		

OUTPUT

Time	Description	Amount in ml
Output Total This Shift		

Measuring Equivalents

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Tea Tumbler = 360 ml
Teaspoon = 5 ml

Tea or Coffee Cup = 240 ml
Gelatin Cup = 120 ml
Soup Bowl = 180 ml
1 ounce = 30 ml

Sherbert/Ice Cream = 120 ml
Pudding = 105 ml
Milk = 240 ml

Nursing Service Policy Manual

Section V M-1
Effective 8/20/08
Supersedes 3/2004

Subject: **Meals and Nourishments**

Purpose: To define the mechanism for monitoring patient meals and nourishments, and ensure appropriate follow-up nutritional concerns.

Authority: CMS Interpretive Guidelines §482.28(b)
2008 Joint Commission Standard PC.7.10
North Carolina Administrative Code .4700

Policy:

1. Food and nutrition are provided for the patient as appropriate to care, treatment, and services. The Registered Nurse (RN) assesses for patient's cultural, religious, and ethnic food preferences at the time of admission and notifies the physician/physician extender/Nutritional Services as appropriate.
2. Nursing Personnel are responsible for assuring that all patients receive meals and nutritional supplements as prescribed.
   a. The ward diet list is updated with any change of diet order. It is reviewed nightly at the time of the 24 hour chart check to ensure accuracy. Corrections in the diet list are made on the electronic list as necessary.
   b. .Prior to serving the meal/tray/nourishment, the nursing employee checks the diet card/ticket/nourishment list to ensure that it is correct.
3. Nutritional intake at meal time is recorded on the Multipurpose Flowsheet by the RN or Licensed Practical Nurse (LPN). The amount eaten is recorded by notating ¼, ½, ¾, or all.
4. The RN or LPN documents patient refusals of meals on the Multipurpose Flowsheet. The RN assesses for a pattern of refusals and reports to the physician/physician extender as appropriate.
5. Patients who refuse the food served are offered substitutes that are of equal nutritional value in order to meet their basic nutritional needs.
6. Eating habits and limitations that affect the patients ability to eat are assessed on admission by the RN.
7. The ward RN monitors the Multipurpose Flowsheet every shift to ensure adequate intake of food. Deviations from normal patterns are reported to the physician/physician extender and documented in the progress notes.
8. Patients requiring assistance during meals receive prompt assistance from nursing personnel based on their abilities and plan of care. Adaptive self-help devices may be provided as ordered or indicated.

9. Three meals are served daily unless medically contraindicated.
   a. Meals are served in designated areas of the Unit.
   b. Patients who are inappropriate for meals off the ward are served in a designated area on the ward. Indications in which staff provide meals on the ward may include, but are not limited to:
      i. Physicians order for "meals on ward" or "ward restriction"
      ii. Behaviorally inappropriate or behavior plan stipulation
      iii. Medical status prohibits leaving ward
      iv. Restrictive intervention in progress

10. Snacks are offered to all patients three times daily in accordance with their prescribed diet. (Exception: Adolescent patients are offered snacks twice daily on school days).
11. Snacks are offered mid-morning and mid-afternoon. A more substantial nourishment is reserved for bedtime.
12. Drinking water shall be available for all patients unless medically contraindicated:
    a. Drinking fountains are located on each patient ward.
    b. Bottled water is available for patient use in each nourishment refrigerator.
    c. Bedside water is provided for patients on the Psychiatric Medical Unit (unless contraindicated).
13. Patients unable to independently drink and/or request water are assisted. Nursing personnel offerer water at least every 2 hours while awake.

Related Policies and Procedures:
Nursing Service Policy V W 1 "Weights"
Nursing Service Procedures "GastrostomyTubes", "Jejunostomy Tubes", "Nasogastic Tubes"
Clinical Care Plan "Intake & Output"

Attachments: None

Nursing Service Policy Manual

Section V M-1
Effective 8/20/08
Supersedes 3/2004

Subject: Meals and Nourishments

Purpose: To define the mechanism for monitoring patient meals and nourishments, and ensure appropriate follow-up nutritional concerns.

Authority: CMS Interpretive Guidelines §482.28(b)
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North Carolina Administrative Code .4700

Policy:

1. Food and nutrition are provided for the patient as appropriate to care, treatment, and services. The Registered Nurse (RN) assesses for patient's cultural, religious, and ethnic food preferences at the time of admission and notifies the physician/physician extender/Nutritional Services as appropriate.
2. Nursing Personnel are responsible for assuring that all patients receive meals and nutritional supplements as prescribed.
   a. The ward diet list is updated with any change of diet order. It is reviewed nightly at the time of the 24 hour chart check to ensure accuracy. Corrections in the diet list are made on the electronic list as necessary.
   b. Prior to serving the meal/tray/nourishment, the nursing employee checks the diet card/ticket/nourishment list to ensure that it is correct.
3. Nutritional intake at meal time is recorded on the Multipurpose Flowsheet by the RN or Licensed Practical Nurse (LPN). The amount eaten is recorded by notating ¼, ½, ¾, or all.
4. The RN or LPN documents patient refusals of meals on the Multipurpose Flowsheet. The RN assesses for a pattern of refusals and reports to the physician/physician extender as appropriate.
5. Patients who refuse the food served are offered substitutes that are of equal nutritional value in order to meet their basic nutritional needs.
6. Eating habits and limitations that affect the patients ability to eat are assessed on admission by the RN.
7. The ward RN monitors the Multipurpose Flowsheet every shift to ensure adequate intake of food. Deviations from normal patterns are reported to the physician/physician extender and documented in the progress notes.
8. Patients requiring assistance during meals receive prompt assistance from nursing personnel based on their abilities and plan of care. Adaptive self-help devices may be provided as ordered or indicated.
9. Three meals are served daily unless medically contraindicated.
   a. Meals are served in designated areas of the Unit.
   b. Patients who are inappropriate for meals off the ward are served in a designated area on the ward. Indications in which staff provide meals on the ward may include, but are not limited to:

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Approval 3-04 NM Team date¶
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. JCAHO Standards
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b. . If an error has been made, it shall be reported to the Dietary Department immediately for correction.¶
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c. . If patient refuses meals, RN assesses and/or a referral to Dietician is implemented.¶
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d. . Meal schedules are unit specific.¶
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Section V M-1¶ ... [2]

i. Physicians order for "meals on ward" or "ward restriction"
ii. Behaviorally inappropriate or behavior plan stipulation
iii. Medical status prohibits leaving ward
iv. Restrictive intervention in progress

10. Snacks are offered to all patients three times daily in accordance with their prescribed diet. (Exception: Adolescent patients are offered snacks twice daily on school days).
11. Snacks are offered mid-morning and mid-afternoon. A more substantial nourishment is reserved for bedtime.
12. Drinking water shall be available for all patients unless medically contraindicated;
    a. Drinking fountains are located on each patient ward.
    b. Bottled water is available for patient use in each nourishment refrigerator.
    c. Bedside water is provided for patients on the Psychiatric Medical Unit (unless contraindicated).
13. Patients unable to independently drink and/or request water are assisted. Nursing personnel offerer water at least every 2 hours while awake.

Related Policies and Procedures:
Nursing Service Policy V W 1 "Weights"
Nursing Service Procedures "Gastrostomy Tubes", "Jejunostomy Tubes", "Nasogastic Tubes"
Clinical Care Plan "Intake & Output"

Attachments: None

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. . Fluids shall be documented in the appropriate space on the multi-purpose flow sheet by recording the fluid intake in cubic centimeters (cc's). (Refer to multi-purpose flow sheet guidelines in the Nursing Procedure Manual, F-11.¶
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NSPOLICY
Section V M-1
Page 1 of 3
Approval 3-04 NM Team date
Approval 3-04 DON date
Effective 3-04
Supersedes 1-15-01

Subject: **Meals and Nourishments**

Purpose: To establish Nursing Services protocol for monitoring meals and nourishments and follow-up.

Authority: JCAHO Long-Term Care Standard
Division of Facility Services Guidelines
JCAHO Standards

Standard: All clients will be provided with adequate meals and nourishments per a regular schedule.

Policy: Nursing Personnel are responsible for assuring that all patients receive meals and nutritional supplements as prescribed.

a. Prior to serving the meal/tray/nourishment, the nursing employee shall check the diet card/ticket/nourishment list to assure that it is correct. (correct patient, correct prescribed meal/nourishment) the physician's order shall be checked, if there is a doubt.

b. If an error has been made, it shall be reported to the Dietary Department immediately for correction.

c. If patient refuses meals, RN assesses and/or a referral to Dietician is implemented.

d. Meal schedules are unit specific.

1. Nursing Personnel shall monitor patients' nutritional needs, record food intake and report significant weight loss/gain. Significant loss/gain shall be defined as: using the last weight on your patient as a baseline, use the following criteria. All patients under 120 lbs a 5% weight loss/gain shall be assessed by an RN. All patients over 120lbs a 10% weight loss/gain shall be assessed by an RN.

a. Food preferences, dislikes, eating habits and abilities/limitations shall be assessed on admission by a RN and the Clinical Dietitian.

b. Food and fluid intake shall be observed and documented on the multi-purpose flow sheet by nursing personnel at each meal/nourishment time. Exceptions to this are acceptable when the patient is under the supervision of the Educational, Rehabilitation Therapy, or Day Hospital Programs.

c. . All patients shall be positioned in a near sitting position as possible during feeding.

d. See attached meal schedule.

3. Nourishments are offered to all patients three times daily in accordance with their prescribed diet. (Exception to this is the Adolescent Unit on school days; on these day Adolescent Unit patients will be offered nourishments twice daily).

a. Nourishments are offered mid-morning and mid-afternoon. A more substantial nourishment is reserved for bedtime.

b. See attached list of nourishment offerings.

4. Drinking water shall be available for all patients unless medically contraindicated.

a. Drinking fountains are located on each patient ward. Bedside water shall be provided for Infirmary patients. Patients shall be oriented to their location.

b. Patients unable to independently drink and/or request water shall be assisted. Nursing personnel shall offer water at least every 2 hours while awake.

Attachments: Meal Service Schedule

Section V N-1
Effective 8-20-2008
Supersedes 7-07-08

Subject: Nursing Process

Purpose: The Psychiatric-Mental Health Nurse collects patient health data, analyzes the assessment data in determining nursing diagnoses and develops a plan of care that prescribes interventions to attain expected outcomes. To provide a consistent format for Nursing Service Personnel to assess, plan, implement, and evaluate quality patient care.

Authority: N.C. Nurse Practice Act, July 2007
ANA Scope & Standards of Practice, 2004
Scope & Standards of Practice for Psychiatric Mental Health Nursing, 2007
Joint Commission Standards PC.2.120, PC.2.130, & PC.2.150
CMS Standards §482.23 (b)(4)
DHSR Standards §.3804
21 NC Administrative Code 36.0224
21 NC Administrative Code 36.0225

Standard: The roles and responsibilities of Nursing Service staff are identified. The assessment, planning, documentation, and evaluation of patient outcomes are established and serve as a guide to Nursing Service Personnel.

Policy:

1. The nursing process is evident in the individual nurse's performance in the care and treatment of patients.
2. Registered Nurses (RNs) are accountable for assessing each individual patient's needs and for planning, implementing, and evaluating the treatment plan.
3. The RN assesses all patients' status at the beginning of each shift. This process involves hand-off communication, ward report, and patient rounds during the shift.
4. There is a nursing component of each patient's interdisciplinary treatment plan. The plan includes nursing strategies directed towards the treatment plans problems and goals. This component of the plan is monitored and evaluated by a RN with recommendations for changes documented on the treatment team progress notes and discussed with the treatment team.

Assessment

5. A pre-admission assessment is completed in the Admission Office prior to the patient going to the ward.
6. A nursing assessment is initiated by the admitting RN on each patient on the shift the patient is admitted. The nursing assessment is documented on the Nursing Assessment form. In the event the nursing assessment cannot be completed within the admitting shift due to the patient's condition/refusal, the RN documents such in the progress notes. The RN communicates via the ward written report and verbally to